STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE
TITLE 28, CALIFORNIA CODE OF REGULATIONS

SECTION 1300.67.241 PRESCRIPTION DRUG PRIOR AUTHORIZATION FORM PROCESS

Control No. 2012-3880

Add new section 1300.67.241 as follows:

Section 1300.67.241. Prescription Drug Prior Authorization Form Process

(a) Health plans, risk-bearing organizations, physicians or physician groups that maintain or are delegated the financial risk for prescription drug benefits and utilize a prescription drug prior authorization process shall use and accept only the Prescription Drug Prior Authorization Request Form, numbered 61-211 (New month/year), which is incorporated herein by reference, and referred to hereafter in this section as "Form No. 61-211."

(b) Health plans, risk-bearing organizations, physicians or physician groups that maintain or are delegated the financial risk for prescription drug benefits that contract with a pharmacy benefit manager to conduct prescription drug prior authorization services, shall require their pharmacy benefit manager to use and accept only Form No. 61-211.

(c) No later than six months after the effective date of the regulation, health plans, risk-bearing organizations, physicians, or physician groups, that maintain or are delegated the financial risk for prescription drug benefits and their contracted pharmacy benefit managers shall do the following:

(1) Make Form No. 61-211 electronically available on their websites.

(2) Accept Form 61-211 through any reasonable means of transmission, including, but not limited to, paper, electronic transmission, telephone, web portal, or another mutually agreeable accessible method of transmission.

(3) Request from the prescribing provider only the minimum amount of material information necessary to approve or disapprove the prescription drug prior authorization request. If additional information for dispensing restricted prescription drugs is required by state or federal law, that information should be submitted as part of section 3. of Form No. 61-211.

(4) Notify the prescribing provider within two (2) business days of receipt of a prescription prior authorization request that either:

(A) The prescribing provider's request is approved; or

(B) The prescribing provider's request is disapproved as not medically necessary or not a covered benefit; or

(C) The prescribing provider's request is disapproved as missing material information necessary to approve or disapprove the prescription drug prior authorization request;

(D) The patient is no longer eligible for coverage; or

(E) The prescription prior authorization request was not submitted on the required form. Please resubmit your request on the attached Form No. 61-211.

(d) Health plans, risk-bearing organizations, physicians or physician groups that maintain or are delegated the financial risk for prescription drug benefits that offer a prescription drug prior authorization process telephonically or through a web portal, shall not require the prescribing provider to provide more information than is required by Form No. 61-211.

(e) Notices to the prescribing provider required under this section shall be delivered in the same manner as the prescription drug prior authorization request was submitted, or another mutually agreeable accessible method of notification.

(f) "Minimum Amount of Material Information" means the information generated by or in the possession of the prescribing provider related to the patient's clinical condition that enables an individual with the appropriate training, experience, and competence in prescription drug prior authorization processing to determine if the prescription authorization request should be approved or disapproved.

(g) In the event the prescribing provider's prescription drug prior authorization request is disapproved pursuant to (c)(4)(B), the notice of disapproval shall contain an accurate and clear written explanation of the specific reason(s) for disapproving the prescription drug prior authorization request. In the event the prescribing provider's prescription drug prior authorization request is disapproved pursuant to (c)(4)(C), the notice of disapproval shall contain an accurate and clear written explanation of the specific material information that is necessary to approve the request.

(h) In the event the notice of disapproval, consistent with the requirements of section (g), is not sent to the prescribing provider within two (2) business days, the prescription drug prior authorization request shall be deemed approved.

(i) Review and Enforcement.

(1) Health plans that delegate the financial risk for prescription drugs to a risk-bearing organization, physician or physician group, shall include a provision in the contract requiring the risk-bearing organization, physician or physician group to comply with section 1367.241 of the Act and this regulation.

(2) Health plans, risk-bearing organizations, physicians or physician groups that contract with a pharmacy benefit manager to conduct prescription drug prior authorization services shall include a provision in the contract requiring the pharmacy benefit manager to comply with section 1367.241 of the Act and this regulation.

(3) Health plans, that delegate the financial risk for prescription drugs to a risk-bearing organization, physician or physician group, or that contract with a pharmacy benefit manager to conduct prescription drug prior authorization services shall have written policies and procedures in place to ensure that the contracted risk-bearing organizations, physicians, physician groups and pharmacy benefit managers comply with section 1367.241 of the Act and this regulation.

(4) The obligation of the health plan to comply with section 1367.241 of the Act and this regulation shall not be deemed to be waived when the plan delegates the financial risk for prescription drug benefits to a risk-bearing organization, physician or physician group, or when the health plan contracts with a pharmacy benefit manager to conduct prescription drug prior authorization services.

(5) Health plans, risk-bearing organizations, physicians or physician groups, or contracted pharmacy benefit managers that require a prescribing provider to utilize a drug specific form other than Form No. 61-211 or require information in excess of the information required by Form No. 61-211 shall subject the health plan to all civil, criminal, and administrative remedies available under the Act.

(6) Failure of a health plan, risk-bearing organization, physician or physician group, or a contracted pharmacy benefit manager to comply with the requirements of section 1367.241 of the Act and this regulation may constitute a basis for disciplinary action against the health plan. The Director shall have the civil, criminal, and administrative remedies available under the Act, including section 1394.

Note: Authority Cited: Sections 1341.9, 1344 and 1367.241, Health and Safety Code.
Reference: Sections 1367.24 and 1367.241, Health and Safety Code.

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: _____ **Plan/Medical Group Phone#:** (_____)_____
Plan/Medical Group Fax#: (_____)_____

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

Patient Information: This must be filled out completely to ensure HIPAA compliance

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg):_____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:		
☐ Physician's Office	☐ Patient's Home	☐ Long Term Care
☐ Ambulatory Infusion Center	☐ Home Care Agency	☐ Other (explain):_____
	☐ Outpatient Hospital Care	

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-9/ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Plan Use Only: Date of Decision:_____

☐ Approved ☐ Denied Comments/Information Requested: _____

_____